

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Los Angeles Comm Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4081 East Olympic Blvd Los Angeles, CA 90023	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control and Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) protocols for two of six residents (Resident 23 and Resident 2), by not wearing the required personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) during suctioning and not maintaining proper infection control practices during wound care. These deficient practices placed Residents 23 and 2 and other residents at increased risk for infection. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 7/30/2025, the H&P indicated Resident 2's diagnoses included a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and an open wound. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills for daily decision-making (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 2 required substantial to maximal assistance from staff to roll left and right in bed and was dependent on staff for all other mobility while in and out of bed. The MDS indicated Resident 2 was dependent on staff for bathing, getting dressed, and toileting hygiene. The MDS indicated Resident 2 had an unhealed Stage 4 pressure injury (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During an observation on 2/2/2026 at 10:13 a.m., at Resident 2's bedside, observed the Treatment Nurse (TN) preparing Resident 2 for wound care treatment. The TN took a box of gloves from the wall mount and placed them onto Resident 2's bed, along with multiple single-use wound dressings. During an observation on 2/2/2026 at 10:25 a.m., at Resident 2's bedside, observed the TN performing wound care treatment to Resident 2's pressure injury. The TN took new gloves from the box of gloves on Resident 2's bed between treatments. The box of gloves were in contact with the plastic bags the TN was using to collect the soiled wound dressings and supplies. During an observation on 2/2/2026 at 10:42 a.m., at Resident 2's bedside, observed the TN taking the box of gloves from Resident 2's bed and returning them back onto the wall mount. The TN was then observed taking an unopened dressing from Resident 2's bed and placing it back onto the treatment cart. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/2/2026 at 10:45 a.m., with the TN, the TN stated he should not have returned the box of gloves to the wall mount. The TN stated returning a box of gloves to the wall mount was an infection control concern because it had already been in contact with Resident 2 and was now contaminated. The TN stated it was okay to return the unused wound dressing to the treatment cart because it was not opened. During an interview on 2/6/2026 at 10:33 a.m., with the Infection Control Manager (ICM), the ICM stated the box of disposable gloves could not be disinfected between use, therefore should be considered contaminated once in contact with a resident. The ICM stated that once the gloves were brought to a resident's bedside it should stay with that resident and not be returned to the wall mount for use with other residents. The ICM stated the dressing should not have been returned to the treatment cart. The ICM stated that the packaging was considered contaminated and could not be disinfected between use. The ICM stated that the box of gloves and the wound dressing were cross-contamination risks and had the potential to spread infection among residents. 2. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was admitted to the facility on [DATE]. Resident 23's diagnoses included hypotension (HTN- low blood pressure), seizures (a chronic brain disorder causing recurring movements due to abnormal electrical activity among brain cells), and chronic renal failure (CKD - long-term, irreversible loss of kidney function where kidneys fail to filter waste from the blood). During a review of Resident 23's History and Physical (H&P), dated 6/16/2025, the H&P indicated Resident 23's was unable to give any information regarding his neurological state of health. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 cognitive skills for daily decision making were severely impaired. During a record review of Resident 23's physician orders dated 1/12/2026, the physician orders indicated Respiratory Therapist assistance for mechanical ventilation (a life-support technique using a machine [ventilator] to assist or replace spontaneous breathing by delivering oxygen) and tracheostomy tube (a tube inserted through a surgical incision (stoma) into the windpipe (trachea) to create an alternative airway for patients who cannot breathe through their mouth/nose due to blockage, long-term ventilation needs, or secretion management) care. During an observation on 2/2/26 at 10:09 a.m., inside Resident 23's room, observed an infection prevention and control protocol sign placed at the entrance of Resident 23's room. Respiratory Therapist (RT) 1 was providing tracheal suctioning to Resident 23 via the resident's tracheostomy tube. RT 1 was not wearing a gown. During an interview on 2/5/2026 at 1:10 p.m., with RT 1, RT 1 stated she forgot to put on a gown before initiating the suctioning care for Resident 23. RT 1 stated Resident 23 was on EBP and that PPE, including a gown, was required per the facility's infection prevention and control policies. RT 1 indicated that by not wearing the required PPE she did not follow established EBP and PPE protocols intended to reduce the transmission of MDROs and other infectious agents. RT 1 stated that suctioning through a tracheostomy involves direct access to the resident's airway and mechanical ventilation system. RT 1 stated failure to wear appropriate PPE increased the risk for contamination of the airway, cross-contamination, and transmission of respiratory infections. RT 1 stated there was a potential for infection-related complications for Resident 23, including respiratory infection and ventilator-associated complications. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions in the Long Term Setting dated 3/2025, the P&P indicated to implement Enhanced Barrier Precautions (EBP) to prevent the transmission of multidrug-resistant organisms (MDROs) and other healthcare-associated infections among residents. The P&P indicated EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP expands upon standard precautions by requiring the use of gowns and gloves during specific high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). During a review of the facility's P&P titled Standard Precautions, dated 6/2025, the P&P indicated standard precautions were the primary strategy for control of hospital-acquired infections. The P&P indicated precautions were designed to prevent the spread of microorganisms. The P&P indicated staff were to prevent infection transmission resulting from indirect contact of a susceptible resident with contaminated objects.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of eight sampled residents (Resident 13 and Resident 24) had informed consent prior to the placement of hand and wrist restraints. This deficient practice resulted in Resident 13 and Resident 24 being placed in restraints without consent from their responsible party. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE]. During a review of Resident 13's electronic medical records, the electronic medical records indicated Resident 13's diagnoses included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 13's History and Physical (H&P), dated 3/4/2025, the H&P indicated Resident 13 was unable to convey any concerns or complaints due to mental status and tracheostomy (trach, an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) status. During a review of Resident 13's Minimum Data Set ([MDS], a resident assessment tool), dated 12/20/2025, the MDS indicated Resident 13's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 13 required maximal assistance (helper does more than half the effort) for upper body dressing. The MDS indicated Resident 13 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 13 required oxygen therapy (treatment that provides supplemental oxygen to help people who can't get enough from normal breathing) and tracheostomy care (cleaning and maintenance of a breathing tube (tracheostomy tube) and the surrounding neck skin (stoma) to prevent infection, ensure clear airways, and manage secretions). The MDS indicated Resident 13 used limb restraints daily while in bed. During a review of Resident 13's care plan titled Bilateral Soft Wrist Restraints dated 6/14/2025, the care plan indicted Resident 13 would not pull out his tracheostomy tube. The interventions indicated to explain the risks and benefits of using restraints to the resident and family. During a review of Resident 13's Patient Orders, dated 2/5/2026, the order indicated bilateral (both) soft wrist restraints to support and promote physical healing, avoid treatment interruptions, and enable active interventions. During a concurrent interview and record review on 2/5/2026 at 10:38 a.m. with the Director of Nursing (DON), Resident 13's Consent for Bilateral Soft Wrist Restraints, dated 6/14/2025, was reviewed. The consent did not indicate consent was obtained prior to applying the soft wrist restraints to Resident 13. The DON stated the name of the person who consented to the application of the soft wrist restraints was required on the consent form. The DON stated it was important to indicate the name of the person that gave consent because it proved the facility received the permission to place the restraints. The DON stated the consent form was incomplete and restraints were placed on Resident 13 without consent. 2. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE]. During a review of Resident 24's electronic medical records, the electronic medical records indicated Resident 24's diagnoses included chronic respiratory failure and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 24's H&P, dated 12/1/2025, the H&P indicated Resident 24 had neurologic (involves the brain, spine, and nerves) and functional limitations. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 24 was dependent on staff for all ADLs. The MDS indicated Resident 24 required oxygen therapy and tracheostomy care. The MDS indicated Resident 24 used limb restraints daily while in bed. During a review of Resident 24's care plan titled Bilateral Soft Wrist Restraints dated 1/2/2025, (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan indicated Resident 24 would be not pull out the trach and tube. The interventions indicated to explain the risks and benefits of using restraints to the resident and their family. During a review of Resident 24's Patient Orders, dated 2/5/2026, the orders indicated right hand mitten restraint to avoid treatment interruptions and enable active interventions. During a concurrent interview and record review on 2/5/2026 at 10:56 a.m. with the DON, Resident 24's Consent for Right Hand Mitten Restraint, dated 1/2/2024, was reviewed. The consent indicated Resident 24 was to have a right hand mitten restraint. The consent form did not indicate consent was obtained prior to the application of the right hand mitten restraint. The person's name who gave consent for the placement of the restraint was not indicated. The DON stated the consent form required the name of the person who gave consent to apply the restraints to Resident 24. The DON stated if the consent did not have a name, it meant the facility did not receive consent to apply restraints to Resident 24. During an interview on 2/6/2026 at 10:42 a.m. with Registered Nurse (RN) 2, RN 2 stated for consent to be complete it must have two RN signatures, the name of the doctor ordering the restraints, and the name of the person giving permission to apply the restraints. RN 2 stated it was negligent to apply restraints on residents without consent. During a review of the facility's Policy and Procedure (P&P) titled Consent/Informed Consent, dated 5/2025, the P&P indicated an informed consent was the process which a patient learns about and understands the purpose, benefits, and potential risks of a medical or surgical intervention, and then agrees to receive the treatment. The P&P indicated a physician was responsible for providing information that was necessary to allow an informed decision to be made.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure as needed (PRN) orders for lorazepam (Ativan, a medication to treat anxiety [feeling of unease]), did not exceed a 14-day administration period for two of 12 sampled residents (Resident 2 and Resident 19). This deficient practice had the potential to result in prolonged administration of lorazepam placing the resident at risk for serious complications such as dependence on the medication, sedation, and withdrawal from prolonged use (the physical and mental symptoms that a person has when they suddenly stop or cut back the use of an addictive substance). Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 7/30/2025, the H&P indicated Resident 2's diagnoses included anxiety disorder (excessive fear of or apprehension about real or perceived threats, leading to altered behavior and often to physical symptoms such as increased heart rate or muscle tension). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 2 had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 2 required substantial to maximal assistance from staff to roll left and right in bed and was dependent on staff for all other mobility while in and out of bed. The MDS indicated Resident 2 was dependent on staff for bathing, getting dressed, and toileting hygiene. During a review of Resident 2's physician order, dated 10/28/2025, the physician order indicated Resident 2 was to receive lorazepam 0.5 milligrams (mg, a unit of dose measurement) every 24 hours PRN for anxiety. During an observation on 2/5/2026 at 1:02 p.m., at Resident 2's bedside, Resident 2 was observed lying in bed. Resident 2's breathing appeared unlabored, even, and he appeared calm when spoken to. Resident 2 was not restless, agitated, or displaying any behavior or mood concerns. During an interview on 2/5/2026 at 1:06 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 was usually very relaxed and used his call light if/when he needed something. CNA 1 stated he had not observed Resident 2 display restlessness or agitation. During an interview with 2/5/2026 at 1:10 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was typically calm but would often get restless and complain of pain to his sacrum (triangular bone in the lower back). LVN 1 stated that aside from restlessness due to pain, Resident 2 did not display agitation or restless behavior. During an interview on 2/5/2026 at 3:03 p.m., with the Director of Nursing (DON), the DON stated that psychotropics ordered for as needed (PRN) administration were to be limited to a 14-day administration period. The DON stated Resident 2's current lorazepam order was ordered for one (1) year. The DON stated the order should have been limited to 14 days and re-ordered if still indicated, but the order duration should not be for one year. The DON stated the purpose of keeping the 14-day duration of administration was to prevent unnecessary use of psychotropic medications. 2. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's H&P, dated 1/9/2026, the H&P indicated Resident 19's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar affective disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had severe cognitive impairment. The MDS indicated Resident 19 was sometimes understood by others and usually understood others. The MDS indicated Resident 19 required substantial to maximal assistance from staff to roll left and right in bed and was dependent on staff for all other mobility while in and out of bed. The MDS indicated Resident 19 was dependent on staff for all hygiene activities. During a review of Resident 19's physician order, dated 1/22/2026, the physician order indicated Resident 19 was to receive lorazepam 1 mg every six (6) (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours as needed for anxiety/agitation. During an interview on 2/5/2026 at 1:14 p.m., with LVN 1, LVN 1 stated Resident 19 was typically confused, requiring reorientation to reality. LVN 1 stated that re-orientation was typically effective in stopping any restlessness or agitation. During an interview on 2/5/2026 at 3:13 p.m., with the DON, the DON stated Resident 19 had an order for lorazepam with a duration of 30 days. The DON stated the order should have been limited to 14 days and reordered if still needed. The DON stated there was no documentation in the record indicating that a duration beyond 14 days was required. During a review of the facility's policy and procedure (P&P) titled Psychoactive Medication, dated 10/2022, the P&P indicated psychoactive (psychotropic, a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications were to be used in the lowest possible dose and discontinued when no longer required. The P&P indicated that when medications were ordered outside of the Unnecessary Drug Guidelines, the physician was to document the reason why the medication was appropriate.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a care plan for three of 12 sampled residents (Resident 2, Resident 7, and Resident 14). This deficient practice placed Residents 2, 7, and 14 at risk of not receiving resident-centered interventions. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 7/30/2025, the H&P indicated Resident 2's diagnoses included a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and an open wound. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 2 had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 2 required substantial to maximal assistance from staff to roll left and right in bed and was dependent on staff for all other mobility while in and out of bed. The MDS indicated Resident 2 was dependent on staff for bathing, getting dressed, and toileting hygiene. During a review of Resident 2's physician order, dated 1/24/2026, the order indicated Resident 2 was to receive hydrocodone-acetaminophen (narcotic combination used to treat moderate to severe pain) 5-325 milligrams (mg, unit of measurement) every 6 hours as needed for severe pain (score of 7-10 on a pain scale, with 0= no pain, 10= worst pain). During an observation on 2/2/2026 at 10:05 a.m., at Resident 2's bedside, Resident 2 was observed with a sacral (tailbone) wound, measuring 10 centimeters (cm, a unit of measurement) long, 4.3 cm wide, and 1.1 cm deep. During an interview with 2/5/2026 at 1:10 p.m., with Licensed Vocational Nurse (LVN) 1, stated Resident 2 had complaints of pain to his sacrum. LVN 2 stated Resident 2 received hydrocodone-acetaminophen to treat his pain which was usually effective. During an interview on 2/5/2026 at 3:07 p.m., with the Director of Nursing (DON), the DON stated Resident 2 did not have a care plan to address his pain or for the administration of hydrocodone-acetaminophen. The DON stated the care plan for hydrocodone-acetaminophen 5-325 mg should include instructions for monitoring including possible side effects such as sedation or dependency. The DON stated the care plan should include interventions for the administration of hydrocodone-acetaminophen 5-325 mg and non-pharmacological interventions. The DON stated the care plan would ensure staff conducted ongoing monitoring of the effectiveness of the interventions being provided to address Resident 2's pain. 2. During observations on 2/2/2026 at 10:18 a.m., and 2/4/2026 at 11:55 a.m., in Resident 7's room, observed Resident 7's hands. Both hands were swollen. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE]. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's electronic medical records, the electronic medical records indicated Resident 7's diagnoses included respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 7's H&P dated 1/29/2026, the H&P indicated Resident 7 was nonresponsive and had anoxic brain injury (brain injury caused by a complete lack of oxygen flowing to the brain). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 7 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 7 required oxygen therapy (treatment that provides supplemental oxygen to help people who can't get enough from normal breathing) and tracheostomy care (cleaning and maintenance of a breathing tube [tracheostomy tube] and the surrounding neck skin [stoma] to prevent infection, ensure clear airways, and manage secretions). The MDS indicated Resident 7 had a Foley catheter (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine). During a review of Resident 7's Patient Orders, dated 12/23/2025, the Patient Order indicated Resident 7 had an order for an indwelling urinary catheter. During a concurrent interview and record review on 2/5/2026 at 1:30 p.m. with the DON, Resident 7's electronic medical records were reviewed. The electronic medical records did not indicate a care plan addressing the resident's Foley catheter or bilateral hand edema (swelling). The DON stated Resident 7 needed a care plan addressing the resident's use of a Foley catheter. The DON stated a care plan would address interventions to prevent infections and provide guidance on how to care for the Foley catheter. The DON stated the risk of not having a care plan was that staff would not know how to care for residents with a Foley catheter. The DON stated Resident 7 also needed a care plan addressing his bilateral hand edema. The DON stated a care plan served as a communication tool to inform staff of the health status of a resident and provided interventions to implement for better resident outcomes. The DON stated without a care plan, staff was not aware of Resident 7's swollen hands. 3. During observations on 2/2/2026 at 10:35 a.m., and 2/4/2026 at 11:22 a.m., in Resident 14's room, Resident 14 was observed with a scab (a dry blood clot on the surface of the skin) above the left side of the upper lip. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. During a review of Resident 14's electronic medical records, the electronic medical records indicated Resident 14 had diagnoses that included (chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and coronary artery disease (artery disease that is caused by plaque buildup in the wall of the arteries that supply blood to the heart, causes coronary arteries to narrow, limiting blood flow to the heart)). During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14's cognitive skills (continued on next page)		

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Los Angeles Comm Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4081 East Olympic Blvd Los Angeles, CA 90023	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for daily decision making was severely impaired. The MDS indicated Resident 14 was dependent on staff for all ADLs. The MDS indicated Resident 14 required oxygen therapy and tracheostomy care. During a concurrent interview and record review on 2/5/2026 at 11:39 a.m. with the DON, Resident 14's electronic medical records, the electronic medical records did not indicate a care plan addressing Resident 14's left upper lip scab. The DON stated Resident 14 should have a care plan. The DON stated Resident 14's left upper lip scab should be treated and initiated in the care plan. The DON stated without a care plan, Resident 14 did not receive the appropriate treatment for his let upper lip scab. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 4/2025, the P&P indicated staff were to ensure a coordinated and comprehensive written plan was developed, based on the resident assessment instrument and on the individual needs of the resident.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff documented and properly assessed bilateral hand edema (swelling caused by an abnormal accumulation of excess fluid trapped in the body's tissues) and documented the scab above a resident's lip for two resident of eight sampled residents (Resident 7 and 14). These deficient practices delayed care for Resident 7 and 14 and placed the residents at risk for complications due to not receiving the necessary care. Findings: a. During an observation on 2/2/2026 at 10:18 a.m. in Resident 7's room, observed Resident 7 lying in bed. Resident 7 had bilateral hand edema. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE]. During a review of Resident 7's electronic medical record, the electronic medical record indicated Resident 7 had diagnoses that included respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 7's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 7 had an anoxic brain injury (brain injury caused by a complete lack of oxygen flowing to the brain) and was nonresponsive. During a review of Resident 7's Minimum Data Set ([MDS], a resident assessment tool) dated 11/12/2025, the MDS indicated Resident 7's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 7 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 7 required oxygen therapy (treatment that provides supplemental oxygen to help people who can't get enough from normal breathing) and tracheostomy care (cleaning and maintenance of a breathing tube [tracheostomy tube] and the surrounding neck skin [stoma] to prevent infection, ensure clear airways, and manage secretions). During a review of Resident 7's electronic medical record, the electronic medical record did not indicate any documentation addressing the resident's bilateral hand edema. During a concurrent interview and record review on 2/5/2026 at 1:30 p.m. with the Director of Nursing (DON), Resident 7's electronic medical record was reviewed. The electronic medical record did not indicate any documentation addressing Resident 7's bilateral hand edema. The DON stated there were no nursing progress notes indicating nursing staff documented the observation of Resident 7's bilateral hand edema. The DON stated nursing staff must document all changes of conditions (COC). The DON stated if the COC was not documented it meant nothing was done to make that change of condition better. The DON stated she expected nursing staff to document all change of conditions, assess residents, inform the family, inform the doctor and carry out the doctor orders. During an interview on 2/6/2026 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she worked with Resident 7 on 2/2/2026, 2/3/2026 and 2/6/2026 and did not notice the bilateral hand edema. LVN 2 stated she noticed Resident 7's right arm was swollen but did not document or report the swelling because she was busy. LVN 2 stated she was required to assess her residents every day and document any new findings. LVN 2 stated swollen hands were a change of condition and needed to be documented. LVN 2 stated all findings must be documented and reported to the physician because Resident 7 might need a higher level of care. b. During an observation on 2/2/2026 at 10:35 a.m. in Resident 14's room, observed Resident 14 lying in bed. There was a scab above Resident 14's lip. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. During a review of Resident 14's electronic medical record, the electronic medical record indicated diagnoses that included (chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and coronary artery disease (artery disease that is caused by plaque buildup in the wall of the arteries that supply blood to the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart, causes coronary arteries to narrow, limiting blood flow to the heart).During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 14 was dependent on staff for all ADLs. The MDS indicated Resident 24 required oxygen therapy and tracheostomy care.During a concurrent interview and record review on 2/5/2026 at 11:39 a.m. with the Director of Nursing (DON), Resident 14's electronic medical record was reviewed. The electronic medical record did not indicate documentation addressing Resident 14's scab above her lip. The DON stated documenting changes of conditions was a way of communicating with all staff. The DON stated if changes of conditions were not documented, nursing staff would be unaware of resident changes.During a concurrent interview and record review on 2/5/2026 at 11:46 a.m. with the DON, the DON stated Resident 14 did not receive any care for the scab. The DON stated she did not know how or when Resident 14 developed the scab because it was not documented.During an interview on 2/6/2026 at 11: 58 a.m. with LVN 2, LVN 2 stated she noticed the scab over Resident 14's lip one month prior. LVN 2 stated she did not notify the physician of Resident 14's scab and she did not document the finding. LVN 2 stated on 2/3/2026, she did not document the finding because the scab began lifting up and she thought it was going to fall off. LVN 2 stated she should have notified her charge nurse. LVN 2 stated Resident 14 did not receive any care or treatment for the scab because Resident 14's physician was not notified. LVN 2 stated she was supposed to document her assessment and monitor Resident 14's scab. LVN 2 stated Resident 14 had the scab for over one month and no one knew how Resident 14 got the scab or what treatment to provide to Resident 14.During a review of the facility's Job Description for LVN dated 2/5/2026, the Job Description indicated LVN's would recognize changes in patient conditions, take appropriate action and document interventions. The Job description indicated an LVN would effectively collaborate with the health care team to intervene, and advocate for the safety of the patient.During a review of the facility's Policy and Procedure (P&P) titled Care of Unconscious Resident dated 4/2025, the P&P indicated the facility would provide the unconscious resident with care that maintained safety, comfort, and minimized complications. The P&P indicated staff would report any changes or unusual observations to the physician. The P&P indicated staff would document significant observations in the nursing narrative notes.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Foley catheter (a flexible indwelling tube inserted through the urethra [a hollow tube that lets urine leave the body] into the bladder to drain urine into a collection bag) drained properly into the collection bag preventing the backflow of urine (when urine flows backward from the bladder to one or both ureters and sometimes to the kidneys) for one of two residents (Resident 20). This deficient practice placed Resident 20 at an increased risk for potential infection, discomfort, obstruction, and decline in health status. Findings: During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was admitted to the facility on [DATE]. Resident 20's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), enlarged prostate (increased in the size of the prostate [a small gland in the male reproductive system]), and seizures (a chronic brain disorder causing recurring movements due to abnormal electrical activity among brain cells). During a record review of Resident 20's History and Physical (H&P), dated 6/17/2025, the H&P indicated Resident 20 was not oriented, non verbal, his and eyes did not visually track (when the eyes focus on an object as it moves across the field of vision). During a record review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 20 was comatose (deep unconsciousness for a prolonged or indefinite as a result of severe injury or illness). The MDS indicated Resident 20 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 02/5/2026 at 1:47 p.m., with Registered Nurse (RN) 1, Resident 20's indwelling Foley catheter was observed hanging from the middle of the bed with a dependent loop (is a formed by excess drainage tubing in a urine drainage system where urine or liquid can accumulate). The Foley catheter was full with urine. RN 1 stated Resident 20's urine was backing up into the resident's bladder and not draining properly because of the dependent loop. RN 1 stated that urine should be able to flow down easily from the Foley catheter tube into the urine collection bag. RN 1 stated that backflow of urine can increase the chances of infection and/or discomfort. RN 1 stated that the Foley catheter should be maintained straight without any dependent loops. During a review of the facility's policy and procedure (P&P) titled Care of the Indwelling Catheter dated 03/2025, the P&P indicated the facility would provide patient comfort and proper urine drainage.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the pulse oximetry (device called placed on a finger or earlobe used to measure the oxygen level of the blood) was applied in order to effectively monitor the oxygen saturation level ([O2 sat], a measurement of how much oxygen the blood is carrying as a percentage) for one of eight sampled residents (Resident 24) receiving respiratory services (treatment, management and care of the patient's breathing). This deficient practice placed Resident 24 at high risk of failing to detect hypoxemia (low blood oxygen), and delayed treatment that can rapidly progress to life-threatening complications. Findings: During observations on 2/2/2026 at 10:22 a.m., and 2/4/2026 at 3:40 p.m., in Resident 24's room, observed Resident 24 was not wearing a pulse oximetry probe. The cord of the pulse oximetry was hanging off the bed. During an observation on 2/5/2026 at 11:00 a.m. in Resident 24's room, observed Resident 24 was not wearing a pulse oximetry probe. The cord of the pulse oximetry cord was unplugged on top of the bed. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE]. During a review of Resident 24's electronic medical records, the electronic medical records indicated Resident 24's diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 24's History and Physical (H&P), dated 12/1/2025, the H&P indicated Resident 24 had neurologic (pertaining to the brain, spine, and nerves) and functional limitations. During a review of Resident 24's Minimum Data Set ([MDS], a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 24's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 24 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 24 required oxygen therapy (treatment that provides supplemental oxygen to help people who can't get enough from normal breathing). During a review of Resident 24's care plan titled Impaired Gas Exchange (process by which oxygen and carbon dioxide move across the air-blood barrier in the lungs, involving ventilation, perfusion, and diffusion) dated 10/1/2021, the care plan indicated Resident 24 was to have an effective gas exchange as evidenced by the pulse oximetry being within normal range. The care plan intervention's indicated to assess and record signs of hypoxia (low tissue oxygen). During a review of Resident 24's Patient Orders, dated 11/17/2025, the orders indicated for oxygen therapy and to maintain oxygen saturation level at 95 percent (%). During a review of Resident 24's Parameter History for Oxygen Saturations, dated 2/2/2026 - 2/5/2026, the Parameter History indicated Resident 24's oxygen saturation was monitored daily. During a concurrent observation and interview on 2/4/2026 at 11:45 a.m. with the Director of Nursing (DON), in Resident 24's room, observed Resident 24 did not have an oximetry probe on her finger. The DON stated she did not know why the pulse oximetry probe was not attached to Resident 24. The DON stated the pulse oximetry probe had to be attached to Resident 24 to monitor the resident's oxygen saturation. During a concurrent observation and interview on 2/4/2026 at 11:58 a.m. with Respiratory Therapist (RT) 2, in Resident 24's room, RT 2 stated Resident 24 should have a pulse oximetry to monitor her oxygen saturation. RT 2 stated he provided respiratory care for Resident 24 that morning (2/4/2026) and she had on the pulse oximetry. RT 2 stated he did not know why it was off. RT 2 stated someone must have taken it off for an unknown reason. RT 2 stated it was important to have the pulse oximetry probe to monitor Resident 24's oxygen level and heart rate and to know if she was hypoxic. During a review of the facility's Job Description for Therapist Respiratory Care Practitioner (RCP), dated 9/18/2024, the job description indicated the RCP was responsible for assessing, planning, implementing, and evaluating the needs of the patient. The job description indicated the RCP (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would evaluate all clinical data to determine the appropriateness of the prescribed respiratory care. During a review of the facility's Policy and Procedure (P&P) titled Pulse Oximetry dated 1/2025, the P&P indicated pulse oximetry would be implemented to monitor oxygen saturation. The P&P indicated spot checks for pulse oximetry would be implemented on each shift when ordered by the physician, residents requiring supplemental oxygen and residents under respiratory care services as part of a routine assessment.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure orders for hydrocodone-acetaminophen 5-325 (brand name Norco, an opioid medication used to reduce moderate to severe pain) did not exceed seven (7) days for one of twelve sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for complications related to administration of opioid medications, such as constipation, nausea, vomiting, sedation, dizziness, respiratory depression, physical dependence, addiction, and overdose. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 7/30/2025, the H&P indicated Resident 2's diagnoses included a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and open wound. During a review of Resident 2's physician orders for the months of October 2025, November 2025, December 2025, and January 2026, the orders indicated to administer Hydrocodone-acetaminophen (Norco) 5-325 milligram (mg, a unit of dose measurement), every 6 hours as needed for severe pain. The orders as follows exceeded the seven (7) day order limit: a. Norco 5-325mg, every 6 hours as needed for severe pain, dated 10/26/25 to 11/25/25b. Norco 5-325mg, every 6 hours as needed for severe pain, dated 11/25/25 to 12/24/25c. Norco 5-325mg, every 6 hours as needed for severe pain, dated 12/25/25 to 1/24/26d. Norco 5-325mg, every 6 hours as needed for severe pain, dated 1/24/26 to 2/23/26 During a concurrent interview and record review on 2/6/2026 at 11:42 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Preparation and Administration of Medications, dated 4/2025 was reviewed. The P&P indicated that all opioid medication orders were to be renewed every 7 days with a new order. The DON stated the purpose of re-evaluating opioid medication for order renewal was to prevent opioid dependency and to prevent the risk for unwanted side effects. The DON stated the facility's P&P was not followed.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the required room size measurement of 80 square feet ([sq. ft.] - a unit of measurement) of room space per resident in one room with multiple residents. This deficient practice had the potential to compromise resident privacy and could potentially affect residents' health and safety. Findings: During a review of the facility's Client accommodations Analysis Form, dated 2/2/2026, the form indicated one room did not meet the 80 square (sq.) foot (ft.) per resident requirement. During a review of the facility's Room Waiver Request Letter, dated 10/10/2025, the letter indicated room [ROOM NUMBER] did not meet the 80 sq. ft. of space per resident requirement. The letter indicated the facility would ensure not to admit ventilator dependent residents (resident who cannot breathe adequately on their own and require long-term, daily, or continuous mechanical support to assist or control their breathing) in that room. The letter indicated if a resident in the room had a change of condition and would need a ventilator (a machine or device used medically to support or replace the breathing of a person), that resident would be moved out of that room. The letter indicated the charge nurse would monitor compliance daily and report any changes to the Subacute Director. The letter indicated the Subacute Director would be responsible for monitoring compliance and would report variations to the environment of care committee on a monthly basis. During observations made throughout the course of the survey, from 2/2/2026 to 2/6/2026, there were no adverse effects that pertained to the residents' care provided by facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. Residents in room [ROOM NUMBER] were not ventilator dependent. During a concurrent interview and record review on 2/5/2026 at 10:10 a.m. with the Director of Nursing (DON), the facility's Room Waiver Request letter, dated 10/10/2025, was reviewed. The Room Waiver Request letter indicated residents on a ventilator would not be admitted to room [ROOM NUMBER]. The DON stated the two residents in room [ROOM NUMBER] were not ventilator dependent and the facility would ensure the residents' health and safety was not adversely affected.		